

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295008		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2009	
NAME OF PROVIDER OR SUPPLIER EL JEN CONVALESCENT HOSP SNF				STREET ADDRESS, CITY, STATE, ZIP CODE 5538 W DUNCAN DRIVE LAS VEGAS, NV 89130			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This Statement of Deficiencies was generated as the result of the annual Medicare re-certification survey in accordance with 42 CFR Chapter IV Part 483 - Requirements for States and Long Term Care Facilities, on 6/23/09 through 6/26/09 with a complaint investigation conducted on 7/2/09.</p> <p>The census at the time of the survey was 131. The sample size was 24 including 3 closed records.</p> <p>The following complaint was investigated:</p> <p>CPT # 22439 - Unsubstantiated</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p>			F 000			
F 241 SS=B	<p>The following deficiencies were identified:</p> <p>483.15(a) DIGNITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure the dignity was maintained for 5 of 26 residents with Foley catheters.</p>			F 241			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2009
NAME OF PROVIDER OR SUPPLIER EL JEN CONVALESCENT HOSP SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 5538 W DUNCAN DRIVE LAS VEGAS, NV 89130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 241	Continued From page 1 Findings include: During the initial tour on 6/23/09 in the morning, two unsampled residents were observed with uncovered Foley catheter bags while sitting in their wheelchairs. On 6/25/09 in the afternoon, Resident #13 was observed lying in bed with an uncovered Foley catheter bag hanging on the bed rail. During the initial tour on 6/23/09 and on 6/24/09 in the morning, Resident #1 and Resident #7 were observed lying in bed with uncovered Foley catheter bag hanging on the bed rail.	F 241			
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to promote healing of an unpreventable pressure sore and failed to accurately document assessment and care of a Stage IV pressure sore for 1 of 24 residents (Resident #18). Findings include: Resident #18	F 314			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2009
NAME OF PROVIDER OR SUPPLIER EL JEN CONVALESCENT HOSP SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 5538 W DUNCAN DRIVE LAS VEGAS, NV 89130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 2</p> <p>Resident #18 was initially admitted on 12/30/08 and re-admitted on 5/28/09 with diagnoses including Severe Peripheral Arterial Disease, Pressure Ulcer Stage III to Coccyx and Right Below the Knee Amputation, Pressure Ulcer Stage IV Left Calf and Right Ear, Pneumonia, Muscle Weakness, Debility, and Chronic Occlusive Disease.</p> <p>Resident #18's Pressure Ulcer Risk Assessment form had a total score of "8" on 12/30/08. The form documented:</p> <p>-"... If the total score is 8 or greater, the resident should be considered at HIGH RISK for skin breakdown and a prevention protocol be initiated immediately..."</p> <p>1. Resident #18 was admitted to the facility on 12/30/08 with no pressure sores noted to the coccyx, sacral, or buttocks areas. A dark purplish area was noted by the nursing staff on the buttocks area on 3/16/09. Along with treatments to the area, the physician ordered for turning every 2 hours on 3/16/09. An initial assessment by the wound care nurse was performed on 3/21/09. A stage I pressure ulcer was noted to the right and left buttocks area by the wound care nurse. The wound care nurse documented on 3/21 that the resident was compliant with turning and repositioning every 2 hours but nursing notes dated 3/16/09 to 4/24/09 documented the resident was non-compliant with repositioning and turning. There was no communication with the nursing staff regarding the patient's noncompliance.</p> <p>On 4/4/09, the wound care physician documented the left buttock pressure ulcer was healed. The</p>	F 314			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2009
NAME OF PROVIDER OR SUPPLIER EL JEN CONVALESCENT HOSP SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 5538 W DUNCAN DRIVE LAS VEGAS, NV 89130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 3</p> <p>right buttock area was a stage III ulcer. New orders for dressing changes to the right buttock was ordered on 4/4/09. The new dressing change orders for the right buttock was placed on the April 2009 Treatment Sheet. The April Treatment Sheet indicated dressing changes to the left buttocks were resolved on 4/4/09.</p> <p>The next wound measurements were completed over 3 weeks later on 4/16/09. The wound care nurse documented on the Weekly Pressure Ulcer Report dated 4/16/09 that the resident was non-compliant with repositioning. The wound care nurse's assessment of the left buttock area was now a stage III pressure sore and the right side was healed. There was no documentation informing the wound care nurse and the wound care physician that the left or right buttocks area had become a stage I, stage II, or a stage III open ulcer. There was no order to treat the stage III left buttock ulcer (wound care nurse's assessment).</p> <p>The April 2009 Treatment Sheet documented dressing changes to the right buttock and the left buttock was resolved on 4/4/09. No new treatments were documented for the left buttock ulcer after 4/4/09, even after a stage III ulcer was noted by the wound care nurse. There was no clarification completed by the wound care nurse regarding where the stage III buttocks wound was located. The physician assessed the left buttocks area as healed on 4/4/09 and the wound care nurse documented that the right buttocks was the healed area.</p> <p>Except for new dressing treatments ordered by the physician on 3/16/09, 4/4/09, and 4/24/09 there were no other preventive actions taken or equipment ordered to prevent worsening of the</p>	F 314			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2009
NAME OF PROVIDER OR SUPPLIER EL JEN CONVALESCENT HOSP SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 5538 W DUNCAN DRIVE LAS VEGAS, NV 89130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 4 wound, even when documentation of non-compliance with turning and repositioning was documented on the nursing care notes from 3/16/09 to 4/23/09. Proper weekly assessments with measurements were not completed by the wound care nurse from 3/16/09 to 4/24/09. The resolved ulcer to the left buttocks was documented by the physician on 4/4/09. There was no documentation the physician was informed about the resident's non-compliance with turning. No other interventions to prevent further breakdown and worsening of the wound were implemented from 3/16/09 until an air mattress was ordered on 4/24/09. The patient was assessed on 4/27/09 with a stage IV right buttock pressure ulcer before being transferred to the hospital. 2. Orders to treat an open area to the right ear lobe were written on 4/23/09. No assessments or measurements were completed to determine progression or worsening to the site. A vague assessment of the site was documented on 4/27/09, prior to Resident #18's transfer to the hospital. On 6/25/09 in the afternoon, the Director of Nursing (DON) indicated wound assessments should be completed with every dressing change. Measurements of the wound should be completed every week.	F 314			
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 315			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2009
NAME OF PROVIDER OR SUPPLIER EL JEN CONVALESCENT HOSP SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 5538 W DUNCAN DRIVE LAS VEGAS, NV 89130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	<p>Continued From page 5</p> <p>catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents had medical justification for a Foley catheter and received the necessary care to prevent urinary tract infections (UTI) for 1 of 24 residents (Resident #1).</p> <p>Findings include:</p> <p>Resident #1</p> <p>Resident #1 was a 55 year old female originally admitted to the facility on 4/11/07 with diagnoses including Cerebral Vascular Accident (CVA) with Left Hemiplegia, Seizure Disorder and Encephalopathy.</p> <p>The resident was readmitted to the facility on 2/3/09 following an acute hospital stay for Urosepsis and Septic Shock requiring intubation and vasopressors.</p> <p>Resident #1 was readmitted on 4/30/09 following an acute admission for Status Epilepticus requiring intubation, Tracheostomy and PEG (Percutaneous Endoscopic Gastrostomy) placement. The Foley catheter was in place upon readmission.</p> <p>On 6/23/09 and 6/24/09, Resident #1 was lying in</p>	F 315			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295008		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2009	
NAME OF PROVIDER OR SUPPLIER EL JEN CONVALESCENT HOSP SNF				STREET ADDRESS, CITY, STATE, ZIP CODE 5538 W DUNCAN DRIVE LAS VEGAS, NV 89130			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 315	<p>Continued From page 6</p> <p>bed and had a Foley catheter to straight drainage in place draining clear, yellow urine.</p> <p>The Bowel and Bladder Assessment Form dated 4/30/09 indicated the "Reason for Catheter - Pressure Ulcer Coccyx/Buttocks."</p> <p>The Nurse's Notes dated 4/30/09 indicated: "...Has Stage II wounds on the Right buttock measuring approx.(approximately) 6 cm (centimeters) x 1.8 cm & Stage II wound on the coccyx measuring 2.5 cm x 1.5 cm."</p> <p>The Weekly Pressure Ulcer Reports revealed: -5/1/09 "Coccyx Pressure Ulcer MDS (Minimum Data Set) stage 2, R (right) buttock Pressure Ulcer MDS stage 2, L (left) Buttock excoriation"</p> <p>-5/15/09 "...continue pressure ulcer to R Buttock MDS stage 2, and coccyx MDS stage 2"</p> <p>- 6/5/09 " Resident noted to have resolved Coccyx pressure ulcer 100% epithelialized, and R Buttock 100% epithelialized."</p> <p>There was no documented evidence that Resident #1's pressure ulcers worsened to a Stage III or Stage IV.</p> <p>There was no documentation by the physician regarding a medical diagnosis for keeping the Foley Catheter in place.</p> <p>The nurse's notes dated 6/15/09 indicated the Foley catheter draining cloudy urine. The physician was notified. A urine specimen was sent to the laboratory on 6/16/09 for culture and sensitivity (C&S).</p>			F 315			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2009
NAME OF PROVIDER OR SUPPLIER EL JEN CONVALESCENT HOSP SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 5538 W DUNCAN DRIVE LAS VEGAS, NV 89130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	Continued From page 7 The results of the urine C&S dated 6/18/09 revealed >100,000 CFU (Colony Forming Units)/ml (milliliter) Gram negative Bacilli; Organism - Proteus Vulgaris. The physician was notified and Resident # 1 was started on Biaxin 500 mg twice a day for 1 week. The physician progress notes dated 6/19/09 indicated "UTI with Proteus Vulgaris." On 6/24/09 in the afternoon, The Director of Nurses (DON) stated a Foley Catheter would be left in place for a Resident with a Stage III or IV pressure ulcer. The DON confirmed Resident #1 never had a pressure ulcer greater than a Stage II and did not have any pressure sores at the current time.	F 315			
F 431 SS=C	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2009
NAME OF PROVIDER OR SUPPLIER EL JEN CONVALESCENT HOSP SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 5538 W DUNCAN DRIVE LAS VEGAS, NV 89130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 431	Continued From page 8 controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure drugs and biologicals were stored properly. Findings include: On 6/23/09 in the afternoon, the refrigerator in the 100 Hall Medication Room contained an undated, open multi-use vial of Influenza Vaccine. On 6/21/09 at 11:45 AM, the medication room on the East Wing contained: - Multi-Delyn Liquid 473 ml (milliliters) - 16 Fluid Ounces; Lot # 4826B; Expiration Date 1/09 - SYSCO Liquid Nectar-Like Consistency 46 Fluid Ounces; #0101675; Received 4/23/09; The container was open and did not have a date opened on the container.	F 431			
F 505 SS=D	483.75(j)(2)(ii) LABORATORY SERVICES The facility must promptly notify the attending physician of the findings.	F 505			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2009
NAME OF PROVIDER OR SUPPLIER EL JEN CONVALESCENT HOSP SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 5538 W DUNCAN DRIVE LAS VEGAS, NV 89130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 505	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure appropriate follow up and notification to the physician of laboratory results for 1 of 24 residents (Resident #21).</p> <p>Findings include:</p> <p>Resident #21</p> <p>Resident #21 was a 75 year old female admitted to the facility on 4/15/09 with diagnoses including Osteoarthritis, Bilateral Knee Surgeries, and Depression.</p> <p>The resident was alert, oriented and able to urinate independently.</p> <p>Documentation in the medical record revealed Resident #21 had Urinary Tract Infections (UTI) confirmed by urine culture and sensitivity (C&S) tests on 5/8/09 and 5/28/09. Resident #21 was treated with antibiotics for 7 days after each urine culture report.</p> <p>The Nurse Practitioner's progress notes dated 6/12/09 indicated "...UTI - recurrent. E-Coli (Escherichia Coli)."</p> <p>Physician orders dated 6/12/09 revealed "Urine C&S".</p> <p>The Nurse's notes dated 6/13/09 indicated the urine specimen was obtained and sent to the laboratory.</p>	F 505			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2009
NAME OF PROVIDER OR SUPPLIER EL JEN CONVALESCENT HOSP SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 5538 W DUNCAN DRIVE LAS VEGAS, NV 89130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 505	Continued From page 10 On 6/25/09 there was no documented evidence of the urine culture and sensitivity results. On 6/26/09, the Director of Nurses (DON) retrieved the final results of the urine C&S which revealed: - >100,000 CFU(Colony Forming Units)/ml Gram Negative Bacilli - E-Coli. The DON contacted the attending physician and Resident #21 was started on Augmentin 500 mg (milligrams) po (by mouth) BID (twice a day)	F 505			
F 514 SS=B	483.75(I)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure accurate documentation in the clinical record to promote coordination of care on 1 of 24 residents (Resident #7). Findings include: Resident #7	F 514			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2009
NAME OF PROVIDER OR SUPPLIER EL JEN CONVALESCENT HOSP SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 5538 W DUNCAN DRIVE LAS VEGAS, NV 89130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 11</p> <p>Resident #7 was an 85 year old female admitted to the facility on 5/19/08 and readmitted on 3/16/09 with diagnoses including Seizures, Cerebral Vascular Accident (CVA) with left Hemiparesis, Hypertension and Depression. The resident was placed on Hospice as of 5/26/09.</p> <p>Resident #7 was being followed by a psychiatrist weekly since 4/09. The psychiatrist's progress notes dated 6/2/09, 6/9/09, 6/16/09 and 6/23/09 indicated:</p> <p>"Resident #7 continues on Celexa 60 mg p.o. (by mouth) q.d. (every day), Wellbutrin SR (Sustained Release) 150 mg p.o. b.i.d. (twice a day) and Risperdal 0.25 mg p.o. b.i.d. which she appears to be tolerating without difficulty."</p> <p>There was no documentation in the psychiatrist's progress notes that Resident #7 was on Hospice.</p> <p>Physician's orders dated 5/26/09 revealed:</p> <p>- "Admit to Odyssey Hospice"</p> <p>- "D/C (Discontinue) the following: "...Risperdal,...Celexa, Wellbutrin..."</p> <p>On 6/25/09, the Medication Nurse confirmed Resident # 7 did not receive these 3 medications since 5/26/09 as per documentation on the Medication Administration Record (MAR).</p>	F 514			